**CONFIDENTIAL PRE-ASSESSMENT QUESTIONNAIRE**

**For adults (16+ years)**

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| **Full Name (please include Mr/Mrs/Ms/Miss):** **Known as:**  |  | **Age:** |  |
| **Date of Birth:** |  |
| **Country of Birth:** |  | **Date moved to the UK:**  |  |
| **Are you adopted?** | **Yes** | **No** | **Prefer not to say** |
| **How do you identify yourself?** | **Male** | **Female** | **Gender neutral** | **Prefer not to say** |
| **The pronouns you use:** | **He/him/his She/her/hers They/them/theirs** **My name only (no pronoun) Other (please state):** |
| **Email address:** |  |
| **Home address:** |  |
| **Term Time address if different:**  |  |
| **Contact Tel No: (mobile)** |  |  **(work)** |  |
| **Contact Email:** |  |

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| **Briefly explain why you wish to be assessed:**  |

**Employment / continuing education**

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| **Are you currently in work?**  | Yes\* / No |
| **Name of employer:**  |  |
| What is your current job title / role? |  |
| Please give details of any previous work you have done: |
| **Are you currently taking a course of study?**  | Yes / No |
| lf Yes, what are you studying? Where? Part time / Full time? |
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| **Have you taken any other courses since leaving school?** If Yes, please give details below: | Yes / No |
| College / University  | Date  | Course  | Qualification gained |
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**School History**

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| **Which secondary schools did you attend?**  |
| **What subjects were you good at?**  |
| **How old were you when your difficulties were first noticed?** |
| **Did you have a good relationship with your teachers?**  | Yes / No |
| **Did you work as hard in school as you might have done?**  | Yes / No |
| **Did you feel you could not keep up, academically, with the others in your class?** | Yes / No |

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| **Did you have any difficulties at school with any of the following?** |
| Reading | No | Slight | Moderate | Severe |
| Spelling  | No | Slight | Moderate | Severe |
| Writing  | No | Slight | Moderate | Severe |
| Mathematics  | No | Slight | Moderate | Severe |
| Essays  | No | Slight | Moderate | Severe |
| Revision  | No | Slight | Moderate | Severe |
| Sport & games  | No | Slight | Moderate | Severe |

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| **Did you have any specialist help at school?**  |  |
| If Yes, please give details, (e.g. Teaching assistant, extra time in exams, Statement/EHCP, specialist tuition) | Yes / No |
| **Was your schooling disrupted in any way?**  | Yes / No |
| **At what age did you leave school?**  |  |

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| **Have you ever seen any other specialists (e.g. speech specialists) or been assessed for learning difficulties such as dyslexia?** | Yes / No |
| lf a written report was given can you let us have a copy?  |  |

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| Medical History **ls your vision within normal limits?** | Yes / No |
| lf No, please give details of problem: **Do you have any visual processing difficulties? (This is not the same as vision).** Yes\*/NoTo ascertain this, please complete the visual checklist (attached) and arrange an assessment by an Optometrist prior to booking the assessment if you have signs of visual processing difficulties.\*If yes, please provide a copy of the report from the Optometrist. |
| **ls your hearing within normal limits?** | Yes / No |
| lf No, please give details of problem: |
| **Have you ever suffered from any serious illnesses?** | Yes / No |
| lf Yes, please give details including any mental health difficulties (including anxiety/depression)  |
| **Do you take any regular medication that may be relevant?** | Yes / No |
| lf Yes, please give details: |
| **Did you have any problems reaching developmental milestones e.g. Learning to walk, tie shoelaces, riding a bike etc.?** | Yes / No |
| lf Yes, please give details: |
| **Were any other languages spoken at home?** | Yes / No |
| If Yes, please give details: |
| **Have any other family members experienced difficulties with spelling / reading / learning?**  | Yes / No |
| If Yes, please give details: |
| **Are there any situations when you do not feel confident?** Yes / NoIf yes please give details:**Previous diagnoses:****Do you have a diagnosis for:** **ADHD? Autistic Spectrum Disorder? Dyspraxia? Anything else? (Please give details)****Are there any modifications you will need in the assessment?**  |
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Do you believe you may have signs of:

 ADHD? Dyspraxia? Autistic Spectrum Disorder?

If so, please ask for a screening questionnaire (ADHD/ Dyspraxia only).

**ln day to day experiences at work, or on any courses you have taken, have you had difficulties with any of the following:**

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| **Communication - do you:** |
| Find it difficult to think of the words to express what you want to say?  | Yes / No |
| Can you give examples? |  |
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| Lose track of what you want to say, or what other people are saying?  | Yes / No |
| Sometimes find you have completely misinterpreted what you have been asked?  | Yes / No |
| Have difficulty following the conversation in group discussions?  | Yes / No |
| Get confused or freeze up if you must speak or read aloud in public?  | Yes / No |
| Sometimes find it difficult to take telephone messages and pass them on accurately?  | Yes / No |

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| **Organisation - do you have problems with:** |
| Planning?  | Yes / No |
| Organising yourself?  | Yes / No |
| Prioritising your workload?  | Yes / No |
| Meeting deadlines?  | Yes / No |
| Working under pressure of time (e.g. in examinations)?  | Yes / No |
| Do you put off starting tasks until the last minute?  | Yes / No |
| Do you get confused over dates and times and miss appointments?  | Yes / No |

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| **Memory and Concentration:** |
| Do you have difficulties remembering instructions/new information?  | Yes / No |
| Do you often lose concentration?  | Yes / No |
| Did you find it difficult to learn your multiplication tables?  | Yes / No |
| Do you sometimes lose track of where you are in a task and have to start again?  | Yes / No |
| Do you find that you experience eye strain when looking at a computer screen for extended periods?  | Yes / No |
| Does writing tend to look blurred or move about on the page when concentrating for extended periods?  | Yes / No |
| Do you find it hard to remember sequences of letters or numbers such as telephone numbers or car registrations?  | Yes / No |

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| **Literacy - do you have problems with:** |
| **Word Reading** |  |
| Identifying the sounds in words? | Yes / No |
| Reading aloud and fear of getting it incorrect? | Yes / No |
| Reading fluently and accurately? | Yes / No |
| A slow reading speed? | Yes / No |
| Needing to track each word when you read using your finger or a book mark? | Yes / No |
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| Understanding what you have read? | Yes / No |
| Difficulty with reading comprehension? | Yes / No |
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| **Listening skills** |  |
| Can you differentiate between different voices that you hear when at school/college/work? | Yes / No |
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| **Writing** |  |
| Taking notes, e.g. at meetings or lectures? | Yes / No |
| Transferring information from one source to another? | Yes / No |
| Producing written reports, essays or other lengthy documents? | Yes / No |
| Proofreading your written work? | Yes / No |
| Summarising information? | Yes / No |
| Identifying key points when faced with large quantities of information? | Yes / No |
| Filling in forms or writing cheques correctly? | Yes / No |
| Do you sometimes muddle up words in sentences so that they don’t make sense or are grammatically incorrect? | Yes / No |
| Do you write long, rambling sentences? | Yes / No |
| Do you tend to write down everything as it comes into your head? | Yes / No |
| Do you avoid writing in front of others? | Yes / No |
| Do you miss out full stops, commas and other punctuation marks? | Yes / No |
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| **Spelling** |  |
| Do you feel your work contains many spelling errors?  | Yes / No |
| Do you miss-spell ‘easy’ words when filling in forms in front of others? | Yes / No |
| Do you miss out little words or the endings of words? | Yes / No |
| Do you avoid using words you cannot spell?  | Yes / No |

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| **Orientation:** |
| Do you have difficulty telling left from right?  | Yes / No |
| Do you find it hard to remember directions?  | Yes / No |
| Do you have difficulties reading road signs especially when driving?  | Yes / No |
| ls map reading, or finding your way to a strange place confusing?  | Yes / No |

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| **Arithmetic - do you:** |
| Tend to forget mathematical operations that are used infrequently?  | Yes / No |
| Find it hard to calculate sums in arithmetic without a calculator?  | Yes / No |
| Find it difficult to do calculations in your head?  | Yes / No |

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| **Coordination and Dexterity - do you:** |
| Have poor coordination?  | Yes / No |
| Find it difficult to learn how to do practical tasks?  | Yes / No |
| Find it difficult to work with small tools or components?  | Yes / No |
| Have difficulties in using a keyboard or mouse?  | Yes / No |
| Often drop things, or bump into things? | Yes / No |
| Did you find it difficult learning to drive? | Yes / No |
| Do you have any current difficulties with driving? | Yes / No |

**Further Information**

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| Please summarise your difficulties and coping strategies. For example: * Have any strategies worked for you so far?
* Do you use strategies which help you remember things?(e.g. thinking in pictures, using ICT).
* How do your difficulties affect your studies, or your performance in the work place?

Please include **any** information which you feel may be relevant. |

* **Please make sure that you fill the following sections in.**

**Use of Data**

Please tick if you would **NOT** like to receive information from Coast Education about their services and product updates by post □ / by email □ (To unsubscribe email: ‘STOP’ to Coast-education.co.uk)

**Permission to Process Data**

* I give my permission for Coast Education to discuss the contents of the

Assessment Report, for (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, carried out on the

(date) \_\_\_\_\_\_\_\_\_\_\_\_, with educators (for example, teachers, lecturers, SENCO) at (name

school/ college/university) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Yes / No (Please circle which ever applies)

* I would like a copy of the diagnostic assessment report sent via email (Yes/No)

If yes, please clearly state the email address to which you would like the diagnostic assessment report sent. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Permission to Process Data**

I confirm that I have requested a diagnostic assessment or screener from Coast Education

for (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on the (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and that I have authority to do so.

I hereby give permission for Coast Education to collect and process data in accordance with their Data Privacy Policy for the purpose of this diagnostic assessment or screener. This may include sensitive data such as educational scores and observations made during the assessment process.

I confirm that I am aware that Coast Education’s Privacy Policy is published on the website [www.coast-education.co.uk](http://www.coast-education.co.uk)

Name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about Coast Education? (Please tick)**

Patoss Register □

British Dyslexia Association Register □

Search Engine (Google/Bing etc.) □

Search Engine then BDA/Patoss Register □

 Personal Recommendation □

Other □ Please state:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this questionnaire to: office@coast-education.co.uk or by post to

The Secretary, 8 Keens Grove, Pilning, Bristol, BS35 4LW before your assessment, or on the day if your assessment is face-to-face.

We need this assessment questionnaire completed to be able to write your report.

Many thanks

**Visual Difficulties Checklist**

**(Acknowledgement to Moody, Singleton and Jameson)**

**This questionnaire should be completed prior to booking the assessment in order to allow time for visual difficulties to be assessed/addressed.**

1. Have you ever used coloured overlays/tinted glasses (Yes/No)?

If YES,

1. who advised and provided them?
2. why were they recommended?
3. did they help?

if YES, then in what way?

1. do you still use them?
2. How many hours reading per day do you do, in a typical week?
3. How many hours do you spend on a screen (phone, tablet or computer) per day, in a typical week?
* **Please complete this tick list questionnaire.**

For this protocol:

* Always = every day
* Often =  several times a week but not necessarily every day
* Sometimes = 2-3 times a month
* Rarely = only once every few months / a year

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| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| 1 | Do you get headaches when you read? |  |  |  |  |  |
| 2 | Does reading make your eyes feel sore, gritty or watery? |  |  |  |  |  |
| 3 | Does reading make you feel tired or sleepy? |  |  |  |  |  |
| 4 | Do you become restless or fidgety or distracted when reading? |  |  |  |  |  |
| 5 | Do you become less comfortable the longer you read? |  |  |  |  |  |
| 6 | Do you prefer dim light to bright light for reading? |  |  |  |  |  |
| 7 | Does reading from white paper seem too bright or glaring? |  |  |  |  |  |
| 8 | Do parts of the white page between the words form patterns when you read? |  |  |  |  |  |
| 9 | Does the print or background shimmer or appear coloured as you read? |  |  |  |  |  |
| 10 | Does print appear to jitter or move on the page as you read? |  |  |  |  |  |
| 11 | Do you screw your eyes up when reading? |  |  |  |  |  |
| 12 | Do you rub your eyes to relieve the strain when you are reading? |  |  |  |  |  |
| 13 | Does text appear blurred, or go in and out of focus, when you read? |  |  |  |  |  |
| 14 | Do you move your eyes around or blink to keep text clear when you are reading? |  |  |  |  |  |
| 15 | Do objects in the distance appear more blurred after you have been reading? |  |  |  |  |  |
| 16 | Do you lose your place when reading? |  |  |  |  |  |
| 17 | Do you re-read or skip words or lines when reading? |  |  |  |  |  |
| 18 | Do you use a marker or your finger to stop you losing the place when you read? |  |  |  |  |  |
| 19 | Do you cover or close one eye when reading? |  |  |  |  |  |
| 20 | Do the words, page or book appear double when you are reading? |  |  |  |  |  |

**Visual symptoms questionnaire**

**Action:** If you have ticked any ‘often’ or ‘always’ symptoms, an optometry referral is always recommended.Where symptoms occur only **sometimes** or **rarely,** a referral could still be made but it may not confirm any visual difficulty. Responses mainly **rarely** or **never** do not warrant onward referral.

The Institute of Optometrists, 56-62 Newington Causeway, London, SE1 6DS Tel: 020 7234 9641. [www.ceriumvistech.com](http://www.ceriumvistech.com) have a local search facility (see ‘*Find your local specialist*’). An optometrist is not the same as an optician.

Visual difficulties should **ideally** be addressed prior to SpLD assessment.